

Specific Care on the Interface of Mental health and Nursing home “SpeCIMeN”

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Valorization addendum

In this chapter, the findings of this thesis are addressed with regard to their societal relevance and usability.

As in other Western Countries, in the Netherlands a policy of ‘aging in place’ and a continuing process of deinstitutionalization of psychiatric care services are encouraged. This means that older people will live at home as long as possible, even if they are frail and disabled. Only when their care needs become too complex and do exceed the possibilities of informal and formal home care, admission to institutional long-term care services is seen as inevitable. Consequently, merely old patients with long-lasting care demands are admitted to long-term care facilities. Among them, there are double care demanding (DCD) patients, who have very complex, and interconnected physical, psychiatric and or cognitive conditions.

Around 13% of all older people over 65 years of age in the Netherlands have a combination of psychological and physical limitations. Two thirds of them receive care and support at home, usually from general practice and home care services, and if necessary in combination with support from ambulatory mental health care services. Sometimes a short-term admission to a mental healthcare institution for diagnosis and initiating of psychiatric treatment is arranged. One third of this group is in need of specific long-term institutional care. Dutch nursing homes had a capacity of 92,000 long-term care beds in 2017. As mentioned earlier in this thesis, 8.4% of these nursing home beds were occupied by DCD-patients, who in fact do exceed the possibilities of a regular nursing home. The prevalence of institutionalized DCD-patients in mental health care facilities remains unknown.

Our study findings have demonstrated that DCD-patients overall represent a challenging and heterogeneous population for both nursing homes and mental health care facilities. They have a highly complex patient profile, with problems in all life domains, a high care dependency and challenging behavioural problems. Therefore, they require care from a specialized multidisciplinary team, skilled in offering tailored care related to the physical, psychiatric and social care domain and with special attention for the care environment and patient safety.

Some clear recommendations from experienced multidisciplinary teams were provided in this study to improve the quality of care for DCD-patients.

Supporting DCD-patients asks for extra knowledge and training in geriatrics, psychiatry, pharmacotherapy, adequate counseling and guiding skills of all team members. Interventions that focus especially on the strengthening of team performance through team coaching, training of reflexivity skills, and collaborative competencies are also highly desirable. Nurses want to be facilitated in acquiring some of these extra skills through training-on-the job in collaboration with *experienced role model nurses*. Aggressive and non-compliant behaviour from patients and sometimes family, is highly demanding to all multidisciplinary team members and necessitates adequate training to cope with this aggression. This implicates that management in both settings must facilitate the possibility of acquiring these needed skills and interventions. They must guarantee sufficient availability and continuity of nursing staff, provide continuous communication about safety within and between staff and management, implement strategies to prevent aggression, and provide follow-up support after encountering aggression incidents. With regard to the DCD-facility, oversight and supervision, preferably with face-to face-contact, must be guaranteed at all times, to create safety for both patients and staff.

When putting together the multidisciplinary team, management should compose a team of members that are highly motivated to work with DCD-patients, and specially focus on creating a working environment with mutual trust, appreciation, support, and respect, to facilitate and enable good teamwork.

This thesis clearly showed that DCD-patients need integrated care because of their complex combinations of mental, physical , and social care needs. Yet access to adequate integrated care and provision of accurate patient information is currently very challenging in the Netherlands, because there is a clear dichotomy between the mental health care and physical health care sector. Different applications of financing, rules and legislation in both these health care sectors, cause various obstacles in the continuity and quality of care for DCD-patients. To ease this unwished situation, and serve the best interest of DCD-patients, the cooperation of multiple health care workers with different professional backgrounds, and from different healthcare settings together with patients and families - so called collaborative practice - is needed within a continuum of appropriate integrated care for DCD-patients. It must be facilitated from a joint vision with regard to DCD-care and regionally organized, as this makes it possible to respond to the way local healthcare is delivered. Mental health consultation services to primary care and nursing homes should be incorporated as part of the care continuum for DCD-patients. These services should consist of visiting mental health consultants -like a psychologist, mental health nurse and psychiatrist- , who assess individual patient problems, provide education, suggest interventions, and provide evidence based psychotherapies and support through ongoing liaison. The deployment of case managers is the key to a successful implementation of collaborative network care, because they can improve communication

between the DCD-patient, the various care providers involved and informal care. This study demonstrated that severe behavioural unpredictability and instability, are grounds to not admit a DCD-patient to a nursing home. This implies that these specific DCD-patients must be cared for in a specialized MH-setting. Hence, enough “DCD-bed capacity” is still necessary in both settings.

In the case of very difficult to place DCD-patients, we recommend an *expert-transfer-team* as a valuable element within the DCD care continuum. This team discusses their service and treatment needs, makes proposals for their optimal placement, and actually arranges this placement, as they operate with authorization of all involved health care providers, the care needs assessment center (CIZ) and health insurers. That would ensure ‘matched care’ for DCD-patients, in other words, the most appropriate care in the most appropriate setting.

Really good cooperation requires the willingness to let others think along and decide what needs to change and to hand over functions and terrain if necessary. Cooperation agreements (transmural and intramural) between primary care, hospital, mental health care and nursing home for this target group must be improved and not laid down without obligation.

It is evident, that the system of artificial regulatory boundaries needs to be adapted in order to better serve DCD-patients with multi-domain problems. Policy makers therefore need to take action to eliminate the existing barriers in rules, legislation and financing systems that hinder real collaborative practice.

DISSEMINATION

Our study results will be widely disseminated to raise broad awareness to the problem of DCD-patients and to convince policymakers, health care insurance companies and health care professionals of the importance of our valorizing advices. They can also be used in the development and provision of interprofessional training programs. As described earlier, an interprofessional “*expert-transfer-team*”, is seen as a useful element within the collaborative care for DCD-patients, within a regional DCD-care continuum. In September 2019, a ZON-MW grant has been acquired to facilitate the development of such an expert-transfer-team. Currently a large mental health care organization (Mondriaan) and four large nursing home care organizations (Cicero, Envida, Meander, Seagram) in the South of the province of Limburg have joined forces to collaborate within the project “the right care in the right place” to ameliorate the care for DCD-patients.

A future challenge could be to focus on combining the expertise of both the MH setting and the nursing home, by letting them blend into a LTC psychiatric nursing facility, where DCD-patients receive treatment and care from a multidisciplinary team employing the expertise of both settings. It might therefore be interesting for future research to compare the different DCD-settings in a MH, a NH and a combined facility, with respect to both patient well-being, staff well-being and cost-effectiveness.